Head to Toe Assessment (Adult – Bedside)

Student Reference Guide

WEST COAST UNIVERSITY

Validate in 211L, 481L, 498L
Practice in 101L, 121L, 210L

Student:

		Faculty Evaluation
NPSG	Wash hands per CDC guidelines ➢ ***MUST* scrub hands at least 20 seconds per CDC hand washing guidelines.**	
NPSG	Introduce yourself ➢ ***MUST* verbalize the procedure you will be performing on the patient and provide the rationale.**	
NPSG	Identify patient correctly using two identifiers (check to chart)	
NPSG	Verify allergy status	
☆☆☆	Provide for patient privacy ➢ ***MUST* physically pull curtain and verbalize "pulling the curtains for your privacy."**	
☆☆☆	Gather Personal Protective Equipment (PPE) and necessary supplies to perform procedure(s). ➢ ***MUST* have all supplies prior to entering the patient's room. If any additional supplies are needed once in the patient's room, points will be deducted during validations.**	
☆☆☆	Maintain proper body mechanics for all procedure(s) during validations.	
NPSG	Dispose of soiled supplies in biohazard bag and wash hands per CDC guidelines after the completion of procedure. ➢ ***MUST* verbalize and physically dispose used supplies in the appropriate disposals.**	

General Survey

Assess level of consciousness: Alert & Oriented x 4 (person, place, time, situation), recent/remote memory ➢ ***MUST* ask appropriate questions to assess the patient's level of consciousness.** ➢ ***MUST* verbalize your assessment on the patients level of consciousness. Example: A&O x4.** ➢ **If the patient is not A&O x4, *MUST* verbalize what the patient is alert and oriented to. Example: Patient is alert and oriented to name and place.**	
Assess overall demeanor of patient: Mood/affect, personal hygiene ➢ ***MUST* verbalize your assessment on the patient's demeanor.**	
Assess communication: Speech (slurred), able to articulate, hearing (Hearing aids or HOH), vision ➢ ***MUST* verbalize your assessment on the patient's communication, speech, hearing, and personal hygiene.**	
Pain: Severity utilizing 0-10 scale ➢ **If the patient is in pain, *MUST* perform a pain assessment.** ☆ **A good pain assessment includes: ☐ Provoking factors ☐ Quality of pain. ☐ Radiation ☐ Severity ☐ Timing**	

Head and Neck

Inspect: Head for bumps, if needed – check hair distribution, infestations and skin integrity ➢ ***MUST* verbalize your assessment.**	
Inspect: Ears for drainage, placement, tenderness and any abnormalities ➢ ***MUST* verbalize your assessment.**	
Inspect: Face – check for symmetry – facial droop, color (pale, flushed, jaundice) ➢ ***MUST* verbalize your assessment.**	
Inspect: Eyes - redness, discharge – contacts, glasses, sclera, extra ocular movements, pupil size, PERRLA ➢ ***MUST* verbalize your assessment.** ➢ ***MUST* physically perform intervention to test for PERRLA.** ➢ ***MUST* have the appropriate equipment(s) to assess for PERRLA.** ➢ ***MUST* know what PERRLA stands for (if asked by the validator).** ☆ **Points will be deducted PERRLA is incorrectly assessed. Must know the correct method to assess for PERRLA through using appropriate equipment.**	
Inspect: Nose – overall condition, any drainage, patency (if applicable) ➢ ***MUST* verbalize your assessment.**	
Inspect: Mouth and gums for moisture, cracked lips, bleeding gums, tongue (swollen), can patient swallow, do they wear dentures, does the tongue move appropriately, breath odor ➢ ***MUST* verbalize your assessment.**	

Inspect: Neck – swollen lymph nodes – note size and location if present, JVD, goiter, deviated trachea ➢ ***MUST*** **verbalize your assessment.**	
Palpate: Head or neck if obvious abnormalities present ➢ ***MUST*** **verbalize your assessment if applicable.**	
Ask: Facial sensation, ability to smell, difficulty seeing, blurred vision, double vision, HOH	

SKIN

Inspect: Skin for breakdown – note location and descriptors if present ➢ ***MUST*** **verbalize your assessment.**	
Inspect: Color –cyanotic, bruising, pale, jaundice ➢ ***MUST*** **verbalize your assessment.**	
Palpate: Skin for temperature – use dorsal part of hand – cool, clammy, hot, dry ➢ ***MUST*** **physically assess temperature with dorsal aspect of your hand and verbalize your assessment.**	
Palpate: Turgor ➢ ***MUST*** **correctly and physically test for turgor.** ➢ ***MUST*** **verbalize if tenting is present.**r	

Upper Extremities

Inspect: ROM, symmetry of extremities able to perform ADL's, shoulders raise and lower, joints stiff or swollen, nails pink, no clubbing noted ➢ ***MUST*** **verbalize your assessment.** ☆ **If both upper extremities has full range of motion, you can verbalize patient has full range of motion on bilateral upper extremities.**	
Palpate: IV Site for tenderness and warmth if applicable ***MUST*** **verbalize your assessment.**	
Palpate: Radial, brachial, ulnar pulses bilaterally – check for deficit ➢ ***MUST*** **know the landmark to check radial pulses and correct method to palpate arteries.** ➢ ***MUST*** **verbalize assessment of radial pulse rate and if deficiency is present.** ☆ **Pulses are typically assessed on a scale from 0 to +3. 0 denotes no pulse, +1 denotes weak pulse, +2 denotes normal pulse, and +3 denotes a bounding pulse.**	
Palpate: Muscle strength in hands ➢ ***MUST*** **correctly perform assessment of ROM.** ➢ ***MUST*** **verbalize your assessment.**	
Palpate: Capillary refill in fingers - brisk, +1, +2 etc ➢ ***MUST*** **correctly perform capillary refill on finger(s).** ➢ ***MUST*** **verbalize your assessment.**	

Thorax, Heart and Lungs

Inspect: Thorax (chest cavity), symmetry, bruising, surgery scars, inspiration and expiration, use of accessory muscles ➢ ***MUST*** **verbalize your assessment.**	
Palpate: Chest wall for tenderness if indicated	
Auscultate: Heart sounds Apical (PMI) ➢ ***MUST*** **verbalize your assessment and if any abnormal findings.**	
Auscultate: Anterior lung fields in 6 places (including laterals) ➢ ***MUST*** **correctly auscultate all lung fields in the correct order through skin to skin contact with stethoscope. Failure to do this will result in deduction of points and possible failure for the entire validation.** ➢ ***MUST*** **verbalize your assessment.**	
Ask: Tobacco use or other substances, respiratory conditions, cough, mucus production, use of 0_2	

Back

Inspect: Position of spine, bruising scaring, skin breakdown (includes the coccyx) ➢ ***MUST*** **verbalize your assessment.**	
Palpate: Back for tenderness including costovertebral if indicated ➢ ***MUST*** **verbalize your assessment.**	
Auscultate: Posterior lungs fields in 8 places including bases (avoid bone) ➢ ***MUST*** **correctly auscultate all lung fields in the correct order through skin to skin contact with stethoscope. Failure to do this will result in deduction of points and possible failure for the entire validation.** ➢ ***MUST*** **verbalize your assessment.**	

	Faculty Evaluation

Abdomen (Gastrointestinal) (Genitourinary)

Inspect: Abdomen for bulging masses, distention, bruising, tubes or drains, scars ➢ ***MUST*** **verbalize your assessment on bulging masses, distention, bruising, and if any tubes or drains are present.**	
Auscultate: Bowel sounds in 4 quadrants – start in RLQ for hypo, hyper or normal ➢ ***MUST*** **verbalize your assessment**	
Percuss: Abdominal quadrants for dull or tympanic sounds if indicated ➢ ***MUST*** **know the correct order of percuss and palpation.** ➢ ***MUST*** **verbalize your assessment.**	
Palpate: Abdominal quadrants for masses or tenderness if indicated ➢ ***MUST*** **know the correct order of percuss and palpation.** ➢ ***MUST*** **verbalize your assessment.**	
Ask: Presence of nausea/vomiting, difficulty eating, last BM (was it normal for patient)	
Inspect: Perineal area for skin breakdown, presence of foley catheter, and overall cleanliness ➢ ***MUST*** **verbalize your assessment.**	
Ask: Presence of pain with urination, blood in urine, dark colored urine, foul odor, frequency, hesitation or burning with urination	

Lower Extremities

Inspect: Legs for symmetry, ROM, muscle strength, hips for stiffness and/or pain, skin for color, temp, bruising, and skin breakdown, hair distribution ➢ ***MUST*** **verbalize your assessment.**	
Inspect: Calves for heat, redness, swelling ➢ ***MUST*** **verbalize your assessment.**	
Inspect: Feet – overall condition, bony prominences for skin breakdown, nails ➢ ***MUST*** **verbalize your assessment.**	
Palpate: Edema ➢ ***MUST*** **verbalize your assessment.**	
Palpate: Dorsalis pedis, post tibial and if needed popliteal pulses bilaterally ➢ ***MUST*** **verbalize your assessment.** ☆ **Pulses are typically assessed on a scale from 0 to +3. 0 denotes no pulse, +1 denotes weak pulse, +2 denotes normal pulse, and +3 denotes a bounding pulse.**	
Palpate: Capillary refill in toes – brisk, +1, +2 etc. ➢ ***MUST*** **verbalize your assessment.**	
Ask: Ability to ambulate, use of assistive devices, and if there are any difficulties with gait (Romberg test if indicated)	

Safety Risks

NPSG	Ask: Suicidal Ideations (Do you have a plan to hurt yourself, or others) ➢ ***MUST*** **ask patient regarding suicidal ideations.**	
	Fall risk: Complete fall assessment as indicated	

Abuse

Ask: History of abuse (Do you feel safe here, or at home)	

NPSG	Wash Hands per CDC Guidelines ➢ ***MUST scrub hands at least 20 seconds per CDC hand washing guidelines.***	
Safety	Ensure safe environment: bed to appropriate height, brakes locked, appropriate side rails up and call light within reach ➢ ***MUST verbalize and physically perform these steps at the end of procedure(s).***	

Completed in 15 minutes using timer: Yes_______ No______

Faculty Evaluator:

Comments: